LONG TERM CARE INTEGRATION PRJECT & HEALTHY SAN DIEGO Addendum #1

As the first version of this paper has been widely circulated, many discussion points have been brought forward. This addendum to the original paper addresses those items in order to be able to continue informed discussion and planning regarding the expansion of Healthy San Diego (HSD) as a service delivery model for the Long term Care Integration Project (LTCIP). Let us remember that the LTCIP Guiding Principles were developed by consensus of the Planning Committee and all decisions to-date have been based on these principles as will future decisions.

Discussion point #1
HSD Health Plans all want to be able to participate at some level in LTCIP.
Response
The California Department of Health Services Office of Long Term Care (OLTC) Integration Unit Chief, Carol Freels, has stated that San Diego will be able to implement several models of Health Plan involvement, to the extent that each complies with the intent and requirements of LTCIP. These models are described y in the section below: **MORE ON HEALTH PLAN OPTIONS**. It is anticipated that LTCIP staff, in working closely with HSD health plans, will respond to issues raised concerning health plan involvement on an on-going basis.

Discussion point #2
HSD Health Plans do not want to lose their current aged, blind, and disabled (ABD) voluntary enrollment members with the implementation of LTCIP.
Response
There will be several models for Health Plan participation (see **MORE ON HEALTH PLAN OPTIONS** below). If a Health Plan chooses to participate under one of these models, voluntary ABD members would remain in the same plan with LTCIP implementation unless the member chose another plan.

Discussion point #3
Community-based organizations (CBOs) currently provide a network of home and community-based services that are integral to the success of LTCIP. Representatives of these organizations want to insure that the Project is not conceptualized nor implemented as a medical rather than social model if Healthy San Diego expansion is chosen as the service delivery vehicle.
Response
Beginning with the authorizing language (AB 1040) in 1995, LTCIP has required an "integrated" model. This is defined in the legislation (W&I Codes Section 14139.05-14130.62) as a system of health, social, and supportive services that has a single point of entry and access supported by pooling the public funds across the continuum of services to create a “seamless system” for the consumer. The Planning Committee and all Workgroups and staff have taken this charge very

seriously, as the break created by funding and eligibility between medical and social/support services currently causes the fragmentation, duplication, and barriers for the aged, blind, and disabled in San Diego.

Locally, the County Board of Supervisors has designated Aging & Independence Services (AIS) as the lead department in planning for LTCIP. With AIS's thirty years' experience in aging, disabled, and home and community-based services (social and supportive services), the organizational structure is in place to fulfill the "letter of the law" in AB1040: to enhance community-based options to prevent hospitalization and institutionalization whenever possible. AIS has a long history in supporting and providing resources to San Diego's CBOs and will continue in this pursuit as LTCIP is planned and implemented.

During Phase I, the Scope of Services Workgroup identified gaps in San Diego's current delivery system that will require additional home and community-based services to be developed and/or provided in additional locations. Under the section below entitled **MORE ON HEALTH PLAN OPTIONS,** contracting health plans will be in the business of procuring social and supportive services for their enrollees. County administration staff of LTCIP, once implemented, will insure that a medical/social model is a priority during LTCIP contract monitoring.

Discussion point #4
CBOs need to get ready for LTCIP by becoming Medi-Cal providers, responding to the County contracting process and gearing up systems.
Response
The state OLTC has agreed that, as a contractor of the health plans to provide home and community-based services, CBOs do not need to be Medi-Cal providers and will not be subject to a county contracting process. Health plans will be required to offer fair and equitable contracts to all existing and qualified home and community-based providers. County administrative staff for LTCIP will define and monitor this process.

Discussion point #5
Healthy San Diego has seven contracting health plans which currently provide acute and primary care to the TANF (Temporary Assistance to Needy Families) population. How will stakeholders be assured that these plans can provide appropriate health, plus social and supportive services to a very different LTCIP population: elderly and disabled individuals?
Response
The Planning committee consensus to explore the Healthy San Diego model's feasibility as a service delivery system for LTCIP was based on our Guiding Principles. Workgroups have already defined necessary elements and consumer

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and provider protections which will be addressed with LTCIP implementation. San Diego's stakeholders are aware that the authorizing legislation calls for managing the care of the elderly and disabled across health, social, and supportive services. It is important to review the rationale for exploring Healthy San Diego as a delivery model for LTCIP as outlined in the original version of this paper. However, successful implementation of the LTCIP will require "**a new model of managed care".** This new model will be characterized by:

a) proactive authorization of services to stabilize consumers at their highest level of functioning and independence;
b) by a single system contact person (care manager) who has responsibility and authority for designing a care plan with the case management team and the consumer and caregivers; and
c) by pooled funding to provide the incentive for health plans to provide social and supportive services before the more costly medical services.

Healthy San Diego's current program has much to offer as a foundation upon which to build LTCIP. These include:

- 10 years of stakeholder input into system development to insure system responsiveness to consumer needs
- 8-10 years of health plan relationship-building and collaboration to improve delivery system integrity as evidenced by the single facility review, quality indicator publication, and development of MOAs with other major providers such as Mental Health, California Childrens' Services, the Regional Center, etc.
- the lowest enrollment default rate in the state due to the county retaining the role of Options Counseling
- acknowledgement by the state Department of Health Services that Healthy San Diego is a successful model with other counties requesting permission to duplicate the model (State staff has voiced the opinion that Healthy San Diego would provide a viable and feasible foundation upon which to build LTCIP service delivery.)
- County and health plans have infrastructure in place upon which to build the "new model of managed care" under Healthy San Diego.
- The Healthy San Diego Designation Process lends itself to the formation of the "new model of managed care" in that the requirements for health plans to provide and manage care across the health, social, and supportive services continuum can be specifically delineated and guaranteed by the plan before the plan is able to contract for LTCIP service delivery.
- The Consumer Center for Health Education and Advocacy, which receives complaints from Healthy San Diego consumers, reports that the 9000 voluntary aged and disabled enrollees currently in Healthy San Diego have not been a source of complaints regarding service delivery.

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Discussion point #6

There has been much activity by Community Eldercare of San Diego (CESD) to develop a local Program for All- Inclusive Care for the Elderly, known as the PACE Program. PACE has proven successful as an integrated health, social, and supportive service model for many years in the United States. CESD would like to have an application for PACE accepted by the State Department of Health Services. Since CESD is ready to gear up for PACE, why not put local energy behind implementing the PACE model rather than trying to create something new for LTCIP?

Response

LTCIP staff has been involved in and supportive of the San Diego PACE Program development for several years. PACE would greatly enrich the set of services currently available in San Diego and would be a contractor under the LTCIP envisioned model. It is important to note that the PACE Program proposed by CESD is to manage the continuum of care for 300 Medicare and Medi-Cal elderly persons who are at a skilled nursing facility level of need in 3 primary and 4 secondary zip codes in the downtown area.

The LTCIP vision is to manage the continuum of care for the majority of the 95,000 individuals throughout the County of San Diego who are eligible to Medi-Cal through the Aged, Blind, and Disabled aid categories. About 60% of these individuals are dually eligible for Medicare and Medi-Cal and a full 50% are under the age of 65. It is estimated that perhaps 25% are at a skilled nursing facility level of need. We must continue to work together toward the implementation of both the PACE Program and the LTCIP in San Diego.

MORE ON HEALTH PLAN OPTIONS

At the state level, both the Office of Long Term Care and Division of Managed Care are supportive of San Diego having several options for health plan participation in the LTCIP. The following narratives are meant to serve as an explanation for the current conceptualization of optional models and are open for discussion and more specific development. At the January 9, 2002 Planning Committee Meeting, Flow Charts depicting the LTCIP delivery system under each of these options will be presented for discussion.

Model A:

A health plan takes full responsibility for provision of the entire continuum of health, social, and supportive services for all ABDs enrolled in their plan. This includes provision of the full range of services as appropriate and as outlined on Attachment C, whether services are provided directly by the health plan and/or through contracts with existing home and community-based care providers.

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Model B:
Under this model, a health plan may choose to provide acute and primary care and contract with another entity to provide “long term care services” once the consumer is identified “at risk”. At all times, the full continuum care manager must have responsibility and authority for coordinating all aspects of the care plan including health, social, and supportive services.

Model C:
Under this model, the capitated health plan contracts with another entity for the delivery and management of the full scope of health, social, and supportive services as listed in attachment C. This “turn-key model” is similar to the Texas Star + Plus relationship between Blue Cross and Lifemark Evercare.

Model D:
A health plan not currently participating in Healthy San Diego may be qualified through the local designation process and contract with the state to become a Healthy San Diego contractor for LTCIP only. Mandatory membership under this model would be authorized for aged, blind, and disabled eligibility categories.